BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of the Eligibility Determination Involving: ALEXANDRA B., Claimant, and INLAND REGIONAL CENTER, Service Agency.	OAH No. L2005060426

DECISION

James Ahler, Administrative Law Judge, Office of Administrative Hearings, heard this matter in San Bernardino, California, on October 10-12, 2005.

Alexandra B. was represented by David A. Grenardo and Michael S. Woodward, Attorneys at Law. Alexandra B. was personally present for a portion of the fair hearing on October 12, 2006, but not otherwise.

Deborah Crudup, Program Manager, represented the Inland Regional Center.

On October 16, 2006, the matter was submitted following the filing of written argument.

ISSUE

Is claimant eligible to receive regional center services and supports as a result of a diagnosis of mental retardation or, in the alternative, as a result of the presence of a disabling condition closely related to mental retardation or requiring treatment similar to that required for mentally retarded individuals?

FACTUAL FINDINGS

The Lanterman Act

1. The Lanterman Developmental Disabilities Services Act (the Lanterman Act) was enacted more than two decades ago. The Lanterman Act is found at Welfare and Institutions Code section 4500 et seq. Welfare and Institutions Code section 4501 states:

> "The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge. Affecting hundreds of thousands of children and adults directly, and having an important impact on the lives of their families, neighbors and whole communities, developmental disabilities present social, medical, economic, and legal problems of extreme importance . . .
>
> An array of services and supports should be established which is sufficiently complete to meet the needs and choices of each person with developmental disabilities, regardless of age or degree of disability, and at each stage of life and to support their integration into the mainstream life of the community. To the maximum extent feasible, services and supports should be available throughout the state to prevent the dislocation of persons with developmental disabilities from their home communities."

Developmental Disability

2. Welfare and Institutions Code section 4512, subdivision (a) defines "developmental disability" as follows:

> "'Developmental disability' means a disability which originates before an individual attains age 18, continues, or can be expected to continue indefinitely, and constitutes a substantial disability . . . As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, but shall not include other handicapping conditions that are solely physical in nature."

3. California Code of Regulations, title 17, section 5400, subdivision (a) provides:

> "(a) 'Developmental Disability' means a disability that is attributable to mental retardation, cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.
>
> (b) The Developmental Disability shall:

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

(3) Constitute a substantial disability for the individual as defined in the article.

(c) Developmental Disability shall not include handicapping conditions that are:

(1) Solely psychiatric disorders where there is impaired intellectual or social functioning which originated as a result of the psychiatric disorder or treatment given for such a disorder. Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have become seriously impaired as an integral manifestation of the disorder.

(2) Solely learning disabilities. A learning disability is a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized mental retardation, educational or psycho-social deprivation, psychiatric disorder, or sensory loss.

(3) Solely physical in nature. These conditions include congenital anomalies or conditions acquired through disease, accident, or faulty development which are not associated with a neurological impairment that results in a need for treatment similar to that required for mental retardation."

Substantial Disability

4. California Code of Regulations, title 17, section 54001, subdivision (a) defines a "substantial disability" as:

"(1) A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and

(2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age: (A) Receptive and expressive language; (B) Learning; (C) Self-care; (D) Mobility; (E) Self-direction; (F) Capacity for independent living; (G) Economic self-sufficiency."

5. Under California Code of Regulations, title 17, section 54001, subdivision (b):

"The assessment of substantial disability shall be made by a group of Regional Center professionals of differing disciplines and shall include consideration of similar qualification appraisals performed by other interdisciplinary bodies of the Department serving the potential client. The group shall include as a minimum a program coordinator, a physician, and a psychologist."

Mental Retardation

6. The *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision* is better known as the *DSM-IV-TR*. It is published by the American Psychiatric Association. The *DSM-IV-TR* discusses all mental health disorders impacting children and adults, lists known causes of those disorders, includes statistics in terms of gender and age at onset, and includes a prognosis for each disorder as well as some of the research concerning the optimal treatment approaches for each disorder.[1]

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[1] The *DSM-IV-TR* contemplates an assessment on several axes, each of which refers to a different domain of information that may help the clinician plan treatment and predict outcome." There are five axes included in the multiaxial classification scheme:

Axis I Clinical Disorders
Other Conditions That May Be a Focus of Clinical Attention

Axis II Personality Disorder
Mental Retardation

Axis III General Medical Conditions

Axis IV Psychosocial and Environmental Problems

Axis V Global Assessment of Functioning.

The Axis I/Clinical Disorder axis is the reason the patient is seeking assistance. The principal diagnosis or reason for the visit is listed as the first diagnosis when more than one Axis I disorder exists.

The Axis II/Personality Disorder axis is used to report specified personality disorders, mental retardation, or prominent maladaptive personality features or defense mechanisms.

The Axis III/General Medical Conditions axis reports current medical conditions that are potentially relevant to the understanding or management of the patient's mental disorder.

The Axis IV/Psychosocial and Environmental Problems axis reports negative life events, environmental difficulties, familial or interpersonal stresses, or other problems relating to the context in which the patient's difficulties have developed.

The Axis V/Global Assessment of Functioning axis reports the clinician's judgment of the individuals overall level of functioning. The "GAF" is rated with respect only to psychological, social, and occupational functioning. A GAF of 91 - 100 indicates superior functioning in a wide range of activities without significant symptoms; a GAF of 81-90 indicates absent or minimal symptoms, with good functioning in all areas, with no more than everyday problems or concerns; a GAF of 71 - 80 indicates if symptoms are present, they are transient and expectable reactions to stressors with no more than slight impairment; a GAF of 61 - 70 indicates some mild symptoms (e.g., depressed mood and mild insomnia) or some difficulty in social, occupational, or school functioning, but generally functioning pretty well; a GAF of 51 - 60 indicates moderate symptoms (e.g. flat affect and circumstantial speech, occasional panic attacks) or moderate difficulty in social occupational or school functioning (e.g. few friends, conflicts with peers or co-workers); a GAF of 41 - 50 indicates serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job); and so on down the line.

Most mental health professionals, including persons working in the field of developmental disabilities, use the *DSM-IV-TR* to establish diagnoses and to devise treatment plans. The *DSM-IV-TR* is considered the "gold standard" in determining whether an individual possesses a diagnosis of "mental retardation."[2]

7. Mental retardation is defined in the *DSM-IV-TR* as "significantly subaverage general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, work, leisure, health, and safety (Criterion B). The onset must occur before age 18 years (Criterion C)."

"General intellectual functioning" is defined by an intelligence quotient (IQ or IQ equivalent) obtained by an assessment utilizing one or more of the standardized, individually administered intelligence tests. The *DSM-IV-TR* specifically mentions the Wechsler Intelligence Scales for Children, 3rd. Edition (WISC-III), the Stanford-Binet 4th Edition, and the Kaufman Assessment Battery for Children as examples of such tests.

"Significantly subaverage intellectual functioning" is defined as "an IQ of about 70 or below (approximately two standard deviations below the mean)." The *DSM-IV-TR* notes there is a measurement error of approximately five points when assessing IQ; thus, it is possible to properly diagnose mental retardation in an individual with an IQ score between 70 and 75 if that individual also exhibits significant deficits in adaptive behavior. The choice of IQ tests and the interpretation of the test results should take into account factors that may limit an individual's test performance, e.g., the individual's background, native language, and associated communicative, motor, and sensory handicaps. If there is a significant scatter in subtest scores, a profile of strengths and weaknesses, rather than a mathematically derived full-scale IQ score, may more accurately reflect the individual's learning abilities. Where there is a marked discrepancy across verbal and performance scores, averaging those scores to obtain a full-scale IQ may be misleading.

"Adaptive functioning" refers to how effectively an individual copes with common life demands and how well the individual meet the standards of personal independence expected of someone in his or her particular age group, sociocultural background, and community setting. Adaptive functioning may be affected may many factors including educational motivation, personality characteristics, social and vocational opportunities, and mental disorders that may coexist with mental retardation. Evidence of deficits in adaptive functioning may be obtained from one or more reliable independent sources (e.g., teachers,

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[2] Although mental retardation is classified as an Axis II disorder in *DSM-IV-TR*, it is not considered a mental illness; rather, that diagnosis identifies groups of people who need social support and special educational services to carry out tasks of everyday living.

There are no specific personality or behavioral features associated with mental retardation. Some individuals with the disorder are placid and dependent, whereas others may be aggressive and impulsive. Lack of communication skills may predispose mentally retarded persons to disruptive and aggressive behavior that substitutes for communicative language. Individuals with mental retardation have a prevalence of comorbid mental disorders that is estimated to be three or four times greater than the general population.

physicians, parents, or home care providers). Several scales have been developed to measure adaptive functioning. The *DSM-IV-TR* specifically mentions the Vineland Adaptive Behavior Scales and the American Association on Mental Retardation Adaptive Behavior Scale as two examples of such instruments. Functional assessments should take into account the suitability of the instrument, as well as the individual's education, associated handicaps, motivation, and cooperation.

8. The *DSM-IV-TR* states there are four degrees of mental retardation: mild mental retardation (characterized by an IQ level of 50-55 to approximately 70); moderate retardation (characterized by an IQ level of 35-40 to 50-55); severe mental retardation (characterized by an IQ level of 20-25 to 35-40); and profound mental retardation (characterized by an IQ level below 20 or 25).

Mild Mental Retardation

9. According to the *DSM-IV-TR*:

> "Mild mental retardation is roughly equivalent to what used to be referred to as the educational category of 'educable.' This group constitutes the largest segment (about 35%) of those with the disorder. As a group, people with this level of Mental Retardation typically develop social and communication skills during the preschool years (ages 0-5 years), have minimal impairment in sensorimoter areas, and often are not distinguishable from children without Mental Retardation until a later age. By their late teens, they can acquire academic skills up to approximately the sixth-grade level. During their adult years, they usually achieve social and vocational skills adequate for minimum self-support, but may need supervision, guidance, and assistance, especially when under unusual social or economic stress. With appropriate supports, individuals with Mild Mental Retardation can usually live successfully in the community, either independently or in supervised settings."

10. An individual diagnosed with "mild mental retardation" in accordance with the *DSM-IV-TR* is eligible for regional center services and supports if that condition constitutes a substantial functional disability and has an onset before age 18.

11. An individual who has achieved an IQ score of 76 or above on an accepted, properly standardized, individually administered intelligence test cannot be considered to be an individual with "mild mental retardation" because that individual lacks significantly subaverage general intellectual functioning under the *DSM-IV-TR* criteria. Thus, an individual who achieves a "best day" IQ score of 76 or above is not eligible for regional center services and supports under the "mentally retarded" diagnosis; this is true even though that individual may have achieved IQ scores of 75 and below in other valid assessments. Why? The nature of the testing does not permit an individual to score higher on an IQ test than the individual's actual level of general intellectual functioning; there are no false positives and no elevated IQ scores.

What services and supports, if any, are available to a person with some IQ scores exceeding 75, but who nevertheless has an enduring, substantially disabling condition closely related to mental retardation or a condition which requires treatment similar to that required for mentally retarded individuals? The Lanterman Act provides eligibility to these persons under the 5th Category.

The 5th Category

12. The "5th Category" is a term used to describe "disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals" but does "not include other handicapping conditions that are solely physical in nature."[3] Along with the other four qualifying conditions (cerebral palsy, epilepsy, autism, and mental retardation), a disability involving the 5th Category must originate before an individual attains age 18 years of age, must continue or be expected to continue indefinitely, and must constitute a substantial disability.

13. The 5th Category is not a condition defined in the *DSM-IV-TR*. Eligibility for Regional Center services under the 5th Category requires a determination of whether an individual functions in a manner that is similar to that of a person with mental retardation or requires treatment similar to that required by individuals with mental retardation under the statute. There has been some disagreement about what conditions are included in the 5th Category. Some disagreement was resolved in *Mason v. Office of Administrative Hearings* (2001) 89 Cal.App.4th 1119. In that opinion, the *Mason* court noted:

> " . . . the terms 'closely related to' and 'similar treatment' are general, somewhat imprecise terms. However, section 4512(a) does not exist, and we do not apply it, in isolation 'Where the language of a statute fails to provide an objective standard by which conduct can be judged, the required specificity may nonetheless be provided by the common knowledge and understanding of members of the particular vocation or profession to which the statute applies.' Here, the Lanterman Act and implementing regulations clearly defer to the expertise of the DDS and RC professionals and their determination as to whether an individual is developmentally disabled. General, as well as specific guidelines are provided in the Lanterman Act and regulations to assist such RC professionals in making this difficult, complex determination. Some degree of generality and, hence, vagueness is thus tolerable.
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> We further recognize that it appears that it was the intent of those enacting the Lanterman Act and its implementing regulations not to provide a detailed definition of 'developmental disability' so as to allow greater deference to the RC professionals in determining who should qualify as developmentally disabled and to allow some flexibility in determining eligibility so as not to rule out eligibility of individuals with unanticipated conditions, who might need services." *Ibid*., at pp. 1128-1129.

[3] Welfare and Institutions Code section 4512, subdivision (a).

14. The Association of Regional Center Agencies published guidelines for determining 5th Category eligibility.[4] In a section of the guidelines discussing whether an individual functions "in a manner that is similar to that of a person with mental retardation," the guidelines specifically state:

> "The higher an individual's IQ is above 70, then the less similar to a person with mental retardation is the individual likely to appear. For example, an individual with an IQ of 79 is more similar to a person with low average intelligence and more dissimilar to a person with mild mental retardation."

and,

> "As an individual's intelligence quotient rises above 70, it becomes increasingly essential for the eligibility team to demonstrate that:
>
> a. there are substantial adaptive deficits, and
> b. such substantial adaptive deficits are clearly related to cognitive limitations."

and,

> "Borderline intellectual functioning needs to show stability over time. Young children may not yet demonstrate consistent rates and patterns of development. For this reason, eligibility for young children in the 5th category should be viewed with great caution."

Alexandra B.

15. Alexandra B. was born in Romania on July 31, 1987. She was placed in an orphanage shortly after birth. Alexandra remained in the orphanage until she was four years old. It was reported that she was malnourished, drugged, left naked, tied to a bed, and physically and sexually abused while she was in the orphanage. Alexandra could not walk and did not develop speech during her stay at the orphanage.

An American couple adopted Alexandra when she was about four years of age. They brought her to their home in Southern California, where she lived with several natural and adoptive siblings. An early assessment was unable to determine a "basal level of language skills" and cognitive skills. Anger management problems were reported. A standardized assessment provided in 1992, when Alexandra was four years, nine months of age, indicated a mental age of three years, three months, a rating of mildly handicapped, which placed Alexandra in the first percentile. Alexandra was given a diagnosis of "severe language delay." She was placed in special education classes, after which she made steady progress in acquiring language.

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[4] The ARCA guidelines have not gone through the formal scrutiny that is required to become a regulation.

16. In May 1996, when Alexandra was eight years, eight months of age, Lenore Schwankovsky, Ph.D., a psychology intern working under the supervision of Mary Moore, Ph.D., evaluated Alexandra. According to Dr. Schwankovsky's report, Alexandra was always well behaved and appeared quite similar to other eight year old girls. She reportedly followed directions well and eagerly. The narrative report indicated her "speech is clear and appropriate" and Alexandra expressed her thoughts and feelings clearly and sometimes quite articulately.

The Leiter International Performance Scale test - a nonverbal test of intelligence frequently used to test for mental retardation and with deaf children - was administered. It produced an IQ score of 89, demonstrating intelligence in the low average range. However, when the WISC-III was administered, it produced a verbal IQ score of 70, a performance IQ score of 65, and a full scale IQ score of 65, demonstrating intelligence in the mildly mentally retarded range.

Dr. Schwankovsky diagnosed Alexandra with "Pervasive Developmental Disorder NOS" and "Parent-Child Relational Problem" on Axis I. No diagnosis was provided on Axis II and III. On Axis IV, Dr. Schwankovsky stated, "Problem with primary support group." The current GAF on Axis V was 65.

Dr. Schwankovsky concluded Alexandra's early deprivation had "resulted in developmental delays in all areas (social, emotional, physical, and intellectual) and probably neurological damage" and that test results "should be interpreted and applied with caution and be seen as indicators of her current functioning." She believed the Leiter testing was the most reliable indicator of Alexandra's current intellectual potential, and that the WISC-III would provide a baseline for future comparison. Dr. Schwankovsky's repot stated, "She is performing at grade level in reading and spelling and one grade below level in arithmetic. Her reading accuracy is also at grade level while comprehension is one grade below."

17. In April 1998, Alexandra was reassessed by Gary L. Smith, a school psychologist. New historical information included a diagnosis of Tourette's Syndrome[5] and a history of taking Ritalin. Alexandra had been enrolled in the county special day class program for multiply handicapped and communicatively handicapped students for about a year, and she had also received language, speech and hearing services before her enrollment in a learning handicapped class. The WISC-III was administered, as well as the Woodcock Johnson Revised Tests of Achievement (WJ-R). Alexandra was noted to be easily distracted during the testing, and she exhibited a flat affect and little self-initiative.

The WISC-III produced a verbal IQ score of 69, a performance IQ score of 77, and a full scale IQ score of 70, which demonstrated intellectual ability in the borderline range. The examiner believed there was a 95 percent probability that Alexandra's true level of overall

[5] Tourette's Syndrome, sometimes referred to as Tourette's Disorder, can be the most debilitating tic disorder. It is characterized by multiform, frequently changing motor and phonic tics. The prevailing diagnostic criteria include onset before the age of 21; recurrent, involuntary, rapid, purposeless motor movements affecting multiple muscle groups; one or more vocal tics; variations in the intensity of the symptoms over weeks to months (waxing and waning); and a duration of more than one year.

intellectual functioning was in the 66-77 IQ range. It was recommended that Alexandra's academic functioning and level of adaptive behavior be thoroughly evaluated (the AAMD Adaptive Behavior Scale or the Vineland Social Maturity Scale were suggested) and that a special education placement for the educable mentally handicapped be considered if other factors (e.g., illness, sensory deficits, significant emotional disturbance, situational or motivational variables) did not account for Alexandra's low performance on the assessment.

With regard to her adaptive behavior, the examiner believed Alexandra's daily living skills were within the normal range, but her impulsive behaviors might require a more involved level of supervision than required for peers.

18. In summer or fall 2000, Alexandra became increasingly out of control in the adoptive home. She did not get along with her adoptive mother, she stole, lied, became angry, and sought revenge against others. Alexandra was hospitalized in a psychiatric setting for approximately two weeks.

In a letter dated November 17, 2000, Maher Kozman, M.D., stated Alexandra had been his patient in an inpatient psychiatric unit, and that she had been diagnosed with Attention Deficit Hyperactivity Disorder, Tourette's Syndrome, Possibly Mood Disorder, Not Otherwise Specified, and mild mental retardation. The letter stated Alexandra also had a history of "pica" and Reactive Attachment Disorder. Dr. Kozman recommended "structured educational environment with provision of behavioral modification interventions" in view of her developmental delays, her tendency to act impulsively, and her past trauma, neglect and abuse. He believed this kind of setting would assist her in better impulse control and would help manage her anger. Dr. Kozman's discharge diagnosis included an Axis II diagnosis of "Mild mental retardation," but it cannot be concluded that that diagnosis of mental retardation was based on any standardized intelligence testing.

Based on the events underlying her psychiatric hospitalization, Alexandra's adoptive parents no longer wanted to have custody of her, and so they sought her out-of-home placement. In some fashion, Alexandra was referred to the Inland Regional Center for evaluation to determine if she was developmentally disabled.

19. Bob Chang, Ph.D., an Inland Regional Center staff psychologist, evaluated Alexandra on November 14, 2000. He obtained background information (new information included a diagnosis of Pica,[6] the administration of several psychotropic medications, and the history of recent inpatient hospitalization at Loma Linda), administered several standardized tests, spoke with Alexandra and her adoptive father, and reviewed the file.

On the WISC-III, Alexandra achieved a verbal IQ score of 82, a performance IQ score of 86, and a full scale IQ of 83, which demonstrated low average intelligence. The

[6] Pica is an eating disorder characterized by persistent and compulsive cravings (lasting 1 month or longer) to eat nonfood items. Pica is most common in persons with developmental disabilities, including autism and mental retardation. Pica may surface in children who've suffered a brain injury affecting development. It can also be a problem for some pregnant women, as well as persons with epilepsy.

scatter in the subtest scores indicated "significant splintering in her cognitive skills." Dr. Chang found Alexandra read in the average range, had borderline spelling abilities, and possessed a learning disorder in arithmetic. With regard to her intellectual status, Dr. Change wrote:

> "Alexandra is clearly not mentally retarded nor does she have a similar condition that requires similar treatment. No records were available regarding Alexandra's birth and early developmental history. Further, the living conditions at the Romanian orphanage may have been a significant factor in her development. The major changes in language and culture should also be considered in the assessment of her abilities. She may have higher potential as she gets older, since she has demonstrated significant gains of the past several years."

With regard to her adaptive functioning, Dr. Chang wrote:

> "Alexandra appears to have the functional potential to perform adaptive tasks at close to age level but her behavior problems significantly limit her ability to perform at age level. She can recite her phone number and complete address. She knows that '911' is for emergencies. She can perform household tasks such as washing dishes/floors, vacuuming, and clean-up tasks. She recognizes coins but she struggles to compute change in purchase. She knows the approximate costs of common items. She is not allowed to use a stove due to the family's concern about safety issues. Her behavioral challenges limit her capacity to function in a responsible and independent manner."

Dr. Change believed that since "Alexandra is exhibiting higher abilities that in previous testing it would be helpful to review her school placement." Dr. Chang concluded Alexandra was ineligible to receive regional center services under the criteria of mental retardation, a similar condition to mental retardation, and/or a disabling condition that requires similar treatment. Dr. Chang recommended family counseling, appropriate school placement, and services through the Department of Behavioral Health Children's Services."

20. Alexandra was removed from her adoptive family's home and became a ward of the juvenile court. In June 2001, Kristy Loufek, a San Bernardino County social worker, was assigned to Alexandra's case. According to Loufek, after Alexandra was removed from the adoptive parents' home, she was placed in a small family home for three months (where she failed to assimilate), and was then placed in a foster family agency home for seven months. Alexandra then resided in a series of structured group facilities including First Street Home, Rancho Damacitas, Rancho Jirah, and in at least two foster homes.

During one of these placements, Alexandra attended Live Oak School, a small non-public school grades kindergarten through 12th, after which she attended Orange Glen High School, a public high school. During this period, she was seen by several counselors.

21. Richard Kleindinst, Ph.D., whose doctorate is in special education and who currently serves as a school psychologist, evaluated Alexandra when she was a student at Live Oak School. Dr. Kleindinst was initially the Director of Live Oak School and he was

later an intern in the field of school psychology. Before his first testing, Dr. Kleindinst knew of Alexandra, who "seemed a little slower" than her peers and who had failed to make expected academic progress.

On June 14, 2001, when Alexandra was 13 years, 10 months old, Dr. Kleindinst administered the Woodcock-Johnson Psycho-Educational Battery, Revised Tests of Achievement. Based on that testing, Dr. Kleindinst concluded when compared to her peers, Alexandra's performance level was in the low average range in broad reading, and her performance levels were very low in broad mathematics and broad written language.

In a handwritten entry on the "Reassessment Review" signed on June 21, 2001, Petty Neumann, the school psychologist, wrote:

> "Due to her background of being identified MH, she has a lot of behaviors that make her look severely handicapped. . . . She has never tested in the retarded range; however, due to severe deprivation as an infant, she functions like a developmentally delayed student. This is learned behavior – in hopes she can avoid trying."

22. In May 2002, about a year after the "review reassessment," Dr. Kleindinst administered several standardized tests including the WISC-III and the Wechsler Individual Achievement Test-II (WIAT-II). On the WISC-III, Alexandra achieved a verbal IQ score of 67, a performance IQ score of 69, and a full scale IQ score of 65, demonstrating mild mental retardation. She was highly social, impulsive, and easily distracted. She required "close supervision during instruction to help her keep focus." Scores in the Cognitive Assessment System (CAS) suggested Alexandra might have delays in adaptive functioning. The result of the Developmental Test of Visual-Motor Integration was in the "very low average range" which was "consistent with her overall cognitive ability." The WIAT-II test results demonstrated Alexandra's abilities were in the lowest percentile, resulting in the conclusion that Alexandra "will continue to struggle in learning from the general curriculum."

A residential staff member completed the Adaptive Behavior Assessment System to assist in the determination of Alexandra's adaptive skills for everyday living. The scaled scores "reflected significant deficits in all adaptive areas with the exception of Leisure."

Dr. Kleindinst concluded Alexandra "has pervasive and significant deficits in all areas of adaptive and functional behaviors" and that she "meets the eligibility criteria for mental retardation [under] C.C.R. Title 5, Sec. 3030(h)."[7] Alexandra was referred back to the Inland Regional Center. Peggy Neumann and Dr. Kleindinst signed the report and they

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[7] California Code of Regulations, title 5, section 3030 provides that a "pupil shall qualify as an individual with exceptional needs, pursuant to Section 56026 of the Education Code, if the results of the assessment as required by Section 56320 demonstrate that the degree of the pupil's impairment as described in Section 3030 (a through j)." Subdivision (h) makes eligible "A pupil has significantly below average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period, which adversely affect a pupil's educational performance."

joined in the observation that Alexandra was mentally retarded for special education purposes and in the recommendation that she be referred to the Inland Regional Center.[8]

23. The results of Dr. Kleindienst's testing were submitted to the Inland Regional Center. The Inland Regional Center decided to retest Alexandra. Patsi Krakoff, Psy.D., a regional center consulting psychologist, was assigned to conduct the assessment.

In September 2002, Dr. Krakoff obtained background information (which curiously included the statement, "She has been in special education classes, and is now in the 8th grade at Live Oak NPS where she is getting some A's and B's."). The presence of this comment suggested a level of educational accomplishment that was misleading. In fact, Alexandra was not a good student and she was not making expected progress.

Dr. Krakoff's review of the prior assessments included the assessment of April 1998 (Factual Finding 15), the assessment of November 2000 (Factual Finding 17), the assessment of May 2002 (Factual Finding 19) and the information contained in the "Reassessment Review" dated June 21, 2001, signed by school psychologist Peggy Neumann stating, "Alex is not retarded; however she performs in the low average range. She has never tested in the retarded range; however due to severe deprivation as an infant, she functions like a developmentally delayed student. This is learned behavior – in hopes she can avoid trying."[9]

Dr. Krakoff administered several standardized tests including the WISC-III (even though that test had been administered within the past year and there was the possibility of an elevated score due to the "practice effect"), the Wide Range Achievement Test-3 (WRAT3), and the Test of Nonverbal Intelligence TONI-3. She spoke with Alexandra and caretakers.

On the WISC-III, Alexandra achieved a verbal IQ score of 70, a performance IQ score of 79, and a full scale IQ score of 67. However, Dr. Krakoff believed these results were not an adequate reflection of Alexandra's true capabilities because she appeared to be unmotivated during the testing process. The scores were "presented as pieces of the puzzle, and other factors must be considered before giving a final diagnosis." The results of the Test of Nonverbal Intelligence – TONI-3 revealed an intelligence quotient of 83. With regard to cognitive testing, Dr. Krakoff concluded:

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[8] Before this fair hearing, Dr. Kleindinst was unaware of regional center eligibility based on the 5th Category. When he met with Dr. Chang at the Inland Regional Center to discuss Alexandra's eligibility for regional center services and supports, Dr. Chang did not explain eligibility under the 5th Category.

[9] Peggy Neumann's comments concerning Alexandra not ever having tested in the retarded range were made about a year *before* testing that concluded Alexandra was retarded, testing with which Peggy Neumann specifically agreed. Dr. Krakoff's juxtaposition of Peggy Neumann's comments with the subsequent testing that disproved those observations was not well understood, except that it appeared to support Dr. Krakoff's ultimate conclusion that Alexandra was not mentally retarded and did not fall within the 5th Category, even though the results of some of Dr. Krakoff's testing was to the contrary.

"Alexandra functions in the borderline to low average range of intelligence. Symptoms of ADHD interfere with accurate measurement of her intelligence. Furthermore, she is not particularly interested in applying strong efforts to the testing process. The scores she obtained on the WISC-III cannot be said to be a valid assessment of her functioning."

With regard to adaptive functioning, Dr. Krakoff wrote:

"She gets dressed by herself and takes care of her personal hygiene and grooming tasks by herself without supervision. She knows how to cook and can use the stove and microwave. She has adequate health and safety awareness. She doesn't know the names of her medications and is dependent on others for this. She doesn't shop by herself, but can indicate her wants and needs. She can take the bus for school. She has little insight and poor judgment for making decisions by herself. She is immature. She is seen as overly friendly without appropriate boundaries. She says she has a best friend and enjoys all sorts of sports. She has unrealistic plans for the future. She is taking medications . . . for mood and behavior regulation."

Dr. Krakoff believed:

"If she were to be treated as a person with mental retardation, her fragile self-esteem could be further damaged. To put her into educational programs for the retarded would be doing her a disservice and would not challenge her potential enough."

Dr. Krakoff concluded Alexandra was ineligible for regional center services under the criteria of mental retardation, a similar condition to mental retardation and/or the presence of a disabling condition that requires similar treatment. She noted that Alexandra did not have a diagnosis of autism, cerebral palsy, or epilepsy. Dr. Krakoff recommended "Special education services through the school without opportunities for mainstreaming" and ongoing counseling to help with mood regulation and issues of self-esteem.

24. By letter dated September 12, 2002, Mary Ann Voss, Consumer Services Representative, Inland Regional Center, advised Alexandra's social worker, Kristy Loufek, that Alexandra was not eligible to receive regional center services and supports based upon Dr. Krakoff's recent assessment.

Subsequent Events and Assessments

25. An effort to obtain regional center eligibility for Alexandra was not pursued for a couple of years. Alexandra was placed in a new foster home in Escondido, California, where she began attending special education classes at Orange Glen High School.

26. Due to her continuing emotional and behavioral problems, Alexandra was referred to Henrietta "Skip" Himelstein, Psy.D., a marriage and family counselor. After five visits or so, Dr. Himelstein discharged Alexandra from therapy. In Dr. Himelstein's letter

dated May 4, 2005, to Kari Crittenden (one of Alexandra's social workers), Dr. Himelstein wrote:

> "Alex is not a good candidate for therapy. Her mental retardation is quite significant and she is not capable of benefiting from any insight therapy, behavioral therapy or cognitive interventions on a weekly basis. Her learning abilities are very limited and, in my view, she needs to be in a structured, supervised environment, such as a group home where she had had constant reminders about her behaviors, beliefs and life direction."

Although Dr. Himelstein did not specialize in the diagnosis or treatment of developmental disabilities, and while was not a regional center vendor, she nevertheless believed Alexandra could benefit form a regional center program because she "doesn't think rationally, is very limited in understanding events and tends to be delusional." These observations were consistent with ongoing mental health problems, but they did not rule out the possibility of a dual diagnosis including a diagnosis of mental retardation.

Dr. Himelstein believed Alexandra functioned at the age of a seven or eight-year-old. She described Alexandra a being very childlike, with a limited intellectual capacity. Dr. Himelstein did not conduct any testing (she was not trained to do so).

27. Janine E. Morris, a school psychologist employed by the Escondido Union High School District, conducted an educational assessment on May 27, 2005. Morris indicated Alexandra was currently a special education student on the basis of mental retardation. Background and other historical information was reviewed, which included a current diagnosis of depression for which Alexandra was taking psychotropic medications. Previous testing (not including regional center testing) was reviewed.

The Wechsler Abbreviated Scale of Intelligence (WASI), a standardized intelligence test, was administered, which yielded a verbal IQ score of 73, a performance intelligence IQ score of 74, and a full scale IQ score of 71, all within the borderline range of intelligence.

An Adaptive Behavior Inventory (ABI) was administered to Alexandra's teacher, Jackie Restivo. The results of that assessment indicated Alexandra possessed average adaptive skills in all areas and, when compared to others her age with mental retardation, she had scores in the high average range.

Morris concluded Alexandra displayed borderline cognitive skills, but given her average visual memory skills and her significant auditory memory deficits, she presented more as a learning disabled student. Morris stated there were no significant social-emotional concerns aside from some hyperactive behavior.

In a "To Whom It May Concern" letter dated June 2, 2005, Morris stated Alexandra was a "very unique girl who has a non-standard profile." The letter mentioned her traumatic history and stated that although Alexandra had grown over time, "she continues to struggle in her development and attainment of new skills." Morris' letter stated that Alexandra was

being placed in a program providing services to students "with severe academic delays with mental retardation."

28. As a result of the testing described in Factual Finding 24, Alexandra was removed briefly from Restivo's severely handicapped class for one period and was placed in a higher level special day class in English with the hope that she would be placed in more special day classes after the initial placement in English proved appropriate.

This experiment was abandoned when Alexandra failed to make enough progress, and she was returned to Restivo's severely handicapped class on a full time basis where she remained though the completion of high school.

29. Jackie Restivo, a very experienced special education teacher, was Alexandra's high school teacher for nearly two years. Restivo had the most personal contact with Alexandra of any witness who testified.

Restivo taught a severely handicapped class of about ten students at Orange Glen High School, about 80 percent of who were mentally retarded. Within this milieu, Alexandra did not stand out as "the best or the brightest." She appeared to Restivo to be mentally retarded. Alexandra proved herself unable to meet the intellectual demands of the special day class and she was returned to Restivo's severely handicapped class, where she got along well with the other severely handicapped students and seemed to enjoy school.

According to Restivo, Alexandra was a very loud, boisterous, emotional student who consistently demonstrated poor judgment, immaturity, and a sense of false bravado. She did not have a fragile sense of self-esteem.

In the area of self-care, Alexandra could read directions, but she was unable to make any real sense of them. Alexandra could toast bread and prepare a bowl of cereal, but she had no cooking skills beyond those. She had no sense of proportion when cooking or eating. Alexandra had good self-hygiene skills and could clean up. She had no sense of personal boundaries and she regularly exposed herself to danger in her interactions with strangers. In the area of communication, Alexandra understood most of what was being said and she could speak clearly. In the area of academic skills, Alexandra performed at approximately the fourth grade level. She made no significant academic progress in the two years she was in Restivo's classroom. Restivo believed Alexandra's academic skills exceeded her adaptive skills. In the area of mobility, Alexandra was not limited in any physical sense, but she lacked the competence to use public transportation. She certainly was incapable of driving a vehicle. In the area of self-direction, Alexandra could make plans, but she was unable to follow through on them. She needed a great deal of supervision. In the area of self-sufficiency, Restivo thought it would be impossible for Alexandra to live independently. She lacked relationship skills and money management skills. In the area of vocation, Restivo thought Alexandra could accomplish janitorial tasks and stocking tasks at retail outlets such as Sav-On Drugs and the Dollar Tree, where some of her other mentally retarded students worked.

Alexandra did not obtain a high school diploma, but she did obtain a certificate of completion.

30. Alexandra's social workers continued to believe that Alexandra might be eligible to regional center services. They sought a redetermination by the Inland Regional Center in early 2005.

31. On May 19, 2005, Mary Joseph-Bacon, Program Manager, Inland Regional Center, advised Loufek that the regional center's review of records established that Alexandra was not eligible for regional center services because she did not "have a substantial handicap due to a diagnosis of cerebral palsy, epilepsy, autism or mental retardation." Joseph-Bacon's letter also made reference to "disability conditions found to be closely related to mental retardation or require treatment similar to that required for mentally retarded individuals."

32. On June 13, 2005, Loufek requested a fair hearing, the purpose of which was to obtain "a fair and accurate assessment of the child, Alexandra B[], so that her level of mental retardation is better assessed and the services she needs better defined . . ."

33. On July 18, 2005, when Alexandra was 17 years, 11 months old, Kenneth Garett, Ph.D., a licensed psychologist, conducted an evaluation which included the administration of the Wechsler Adult Intelligence Scales, Third Edition (WAIS III). Alexandra's verbal IQ score on that standardized intelligence test was 71, her performance IQ score was 69, and her full scale IQ score was 67. Dr. Garett believed the test results were valid.

The Wide Range Achievement Test-Third Revision (WRAT-III) was administered, which resulted in standard scores equivalent to a fourth grade reading level, a third grade spelling level, and a third grade arithmetic level. Dr. Garett believed Alexandra was cooperative and completed the tasks at a level consistent with her abilities.

Dr. Garett noted that the IQ scores from all the previous testing (including Dr. Krakoff's Wechsler assessment) indicated Alexandra was functioning in the mildly developmentally disabled range, except for Dr. Chang's assessment in 2000. He believed the TONI-3 assessment was "grossly inaccurate." Dr. Garett noted the presence of significant behavioral problems.

Dr. Garett determined Alexandra performed basic self-help skills consistent with her diagnosis of mildly mentally retardation. She dressed independently, but she could not choose her own clothing. He noted that Alexandra had worked in a kennel, but lost that job when she stole an insignificant item. He stated Alexandra was unable to travel within the community independently and did not operate effectively with money. Alexandra's general behavior was noted to be significantly younger than that of a child her chronological age

Dr. Garett's assessment was forwarded to the Inland Regional Center for review.

34. An informal conference was held concerning Alexandra's eligibility for regional center services. The Inland Regional Center again denied Alexandra eligibility for such services. Loufek signed a waiver of time set for a fair hearing and determination to enable the regional center to consider further evidence that might be available. Ultimately, when an agreement could not be reached, the matter was set for a fair hearing.

Dr. Zimmerman's Assessment

35. Robert (Rob) Zimmerman, Psy.D. received his doctorate in psychology from Loma Linda University in December 1998. He completed an internship and residency in Provo, Utah, at Wasatch Mental Health, providing outpatient assessment and treatment of youth, family, and adults. He was in solo practice in Washington and Utah from 2001 through 2002. He became a staff psychologist with the Inland Regional Center in November 2002 and has continued with that employment since. Much of Dr. Zimmerman's time is spent evaluating individuals to determine if they are eligible to receive regional center services and supports. He estimated that he has evaluated several hundred persons for eligibility purposes since he began his employment with the Inland Regional Center.

Dr. Zimmerman was very familiar with the term "developmental disability" as used in the Lanterman Act, with "mental retardation" as defined in the *DSM-IV-TR*, with relevant provisions of the Welfare and Institutions Code and California Code of Regulations, title 17, and with the 5th Category guidelines adopted by the Association of Regional Center Agencies.

Dr. Zimmerman believed intelligence testing was an essential element in determining whether a person was "mentally retarded" for regional center purposes and he credibly testified that in a series of tests with inconsistent results, the highest IQ test score represented the individual's "best moment of the best day." He credibly testified that a person can attain a lower score than his or her actual intelligence quotient, but a person cannot attain a higher IQ score than he or she is capable of achieving if the test is properly administered. As Dr. Zimmerman testified, "You can't guess your way to a high score."[10]

36. Dr. Zimmerman reviewed numerous reports and records including Dr. Schwankovsky's report; the April 29, 1998, psychoeducational evaluation; the November 14, 2000, psychological evaluation and Dr. Chang's report; the November 17, 2000, psychiatric assessment by Dr. Kozman; admission/history evaluations and quarterly reports from East Valley Charlie; the September 9, 2002, evaluation by Dr. Krakoff; quarterly reports from Thessalonika Family services; needs and service plans from the Department of Social Services; IEP meeting notes; Dr. Himelstein's letter dated May 4, 2005; the psychoeducational assessment dated May 27, 2005; and, Dr. Garett's evaluation dated July 18, 2005.

[10] There might be an artificial elevation in the IQ score due to the "practice effect" if the same test is repeated within a year, but not thereafter. The "practice effect" was not a significant concern in this matter.

37. On February 15, 2006, Dr. Zimmerman met with Alexandra and her two social workers for approximately 90 minutes. He conducted a clinical interview, administered the Reynolds Intelligence Assessment Scale (RIAS), the Scales of Independent Behavior, Revised, Short Form (SIB-R), and the Street Survival Skills Questionnaire (SSSQ). He did not administer the WAIS-III because Dr. Garett had administered that instrument within the past year and there was a possibility of a practice effect. Following his assessments, Dr. Zimmerman prepared a comprehensive 16-page narrative report.

38. Dr. Zimmerman reached several conclusions. During the initial portion of the mental status exam, Alexandra's face was expressionless. She carried a stuffed animal. She became expressive when discussing her interests, after which she was generally personable and cooperative. She did not need directions and she did not need repetition to complete the tasks presented to her. Alexandra's speech was "fairly childlike" during the assessment, and she insisted that one of her case worker's be present throughout. She was not suicidal or homicidal, and she had no hallucinations or delusions. She had no mood swings and was not agitated. She was oriented to person, place, time, and things.

The RIAS assessment resulted in a finding of "low average abilities," with a verbal intelligence quotient score of 80, a nonverbal intelligence quotient score of 85, and a composite intelligence score of 80.[11] In his testimony, Dr. Zimmerman stated Alexandra scored in the borderline to low average IQ range.

Dr. Zimmerman discounted many of results obtained in prior assessments. In some instances, he believed the results were not reliable or valid because there was a great difference between Alexandra's verbal and performance IQ scores; in other instances, he discounted the results because there was significant scatter in subtests in a particular assessment; and in other instances, he discounted the results because there was significant scatter in subtests from the several different assessments. Dr. Zimmerman was particularly cautious in accepting the reliability of assessments which yielded low index scores. And, he testified Dr. Kleindienst's narrative report "did not appear to be the profile of someone with mild mental retardation." Dr. Zimmerman cited Alexandra's apparent lack of effort to support Dr. Krakoff's observations concerning the invalidity of her testing; yet, he did not credit the observations of other examiners who commented upon Alexandra's cooperation during their testing, instead asserting that Alexandra's lack of motivation was the likely reason for low index scores.

Dr. Zimmerman was understandably reluctant to blindly accept an Axis II diagnosis of mental retardation, such as that provided by Dr. Kozman (Factual Finding 16) or a simple conclusion that Alexandra's mental retardation was "quite significant" as mentioned by Dr. Himelstein (Factual Finding 23) when that diagnosis was not based on testing.

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[11] The RAIS is a standardized instrument used to test intelligence, but the RIAS is not mentioned in the *DSM-IV-TR*.

Dr. Zimmerman reviewed the previous intelligence testing and, using a novel approach involving the compilation of selected "best effort" subtest scores, he concluded that Alexandra's range of intellectual potential necessarily included a verbal IQ score of 79-92 and a performance IQ score of 80-94, which was a profile consistent with "low average" abilities. Dr. Zimmerman's development and novel use of this "best effort" analysis was interesting, but the methodology was not suggested by the *DSM-IV-TR* or any other evaluative authority.[12]

With regard to the Escondido Union High School District's assessment, Dr. Zimmerman observed that it mentioned that Alexandra "was on track to graduate" and was interested in the Job Corps, interests which were inconsistent with the kinds of interests reasonably expected of persons with mental retardation. In this regard, Dr. Zimmerman confused Alexandra's right to receive a certificate of completion with the right to receive a diploma, and he failed to mention that Alexandra's interest in joining the Job Corps and becoming a law enforcement officer was unrealistic.

Dr. Zimmerman concluded, "Alex's intellectual abilities are dissimilar to the diagnosis of mental retardation."

Alexandra was the sole informant concerning her ability to solve a wide variety of challenges, which was based on her responses to the SSSQ.[13] Neither the Vineland Adaptive Behavior Scales nor the American Association on Mental Retardation Adaptive Behavior Scale was administered, even though two of Alexandra's social workers were present.

Based on her responses to the SSSQ flip cards, Dr. Zimmerman concluded Alexandra's ability to read and understand common community functional signs was in the average range, her knowledge of home-based activities was in the above average range, her knowledge of general health and safety procedures was borderline, her knowledge of public services was average, her ability to understand time was average, but her ability to identify and use U.S. currency was deficient. Dr. Zimmerman believed that some of Alexandra's limitations might be based on mental health issues.

With regard to her adaptive deficits, Dr. Zimmerman concluded, "Available information indicates that Alex's adaptive deficits stem from a psycho-social deprivation, a specific learning disability, and specified psychiatric conditions."

Dr. Zimmerman noted that, in general, treatments required by a mentally retarded person would taken into account the person's significantly subaverage general intellectual

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[12] The use of a "best day" profile can be misleading. For example, a professional baseball player with average skills might have an undistinguished career, yet a highlight film of his time in the major leagues might include a couple of grand slam homeruns, numerous diving catches, several stolen bases, and other memorable moments. The compilation of the this ballplayer's best moments would not earn him entry into the Hall of Fame in Cooperstown, an All-Star baseball game, or perhaps even a spot on the starting lineup.

[13] The SSSQ is a standardized instrument used to assess functional behavior, but it is not mentioned as an example of such in the *DSM-IV-TR*.

abilities, and would demonstrate a need for basic communication and vocabulary. Treatment methods would include repetitive demonstrations, repeated training trials, hand-over-hand training, and chaining techniques to gradually join simple skills together. According to Dr. Zimmerman, "There is no history of this type of treatment being of benefit." While Alexandra had benefited from a structured living environment with consistent supervision, this was not a treatment condition exclusive to mentally retarded persons and it would be just as useful in the treatment of those with a mental condition.

With regard to Alexandra's need for treatment similar to that required for mentally retarded individuals, Dr. Zimmerman wrote, "Treatments for the mentally retarded would be inappropriate and potentially counterproductive." Dr. Zimmerman testified that if Alexandra were placed in a program with mentally retarded persons, she would begin functioning as a mentally retarded person and would experience a decline in motivation. Dr. Zimmerman said he found no evidence in the materials he reviewed to establish that Alexandra benefited from any treatment indicated for mentally retarded persons.

Dr. Zimmerman's *DSM-IV-TR* diagnosis was:

Axis I:	Reactive Attachment Disorder (by history) Mood Disorder, NOS (by history) Mathematics Disorder Psychotic Disorder, NOS Rule Out ADHD, Impulsive Type
Axis II:	No Diagnosis or Condition
Axis III:	Tourette's Disorder (by history).

39. Dr. Zimmerman conceded that the Inland Regional Center provides services and supports to persons with dual diagnoses (i.e., mental retardation and some other mental health condition) and that persons with mental retardation are three or four times more likely than the general population to experience such mental health problems.

40. Dr. Zimmerman reviewed the adaptive and functional testing recently obtained by Dr. Raymond G. Murphy and stated he believed the results of that functional testing were generally valid.

41. Dr. Zimmerman testified that other qualified practitioners in the field of developmental disabilities might interpret the data he reviewed and based his conclusions upon in a much different fashion and they could reasonably conclude that Alexandra was entitled to regional center services under the 5th Category.

Dr. Raymond Murphy's Assessment

42. Raymond G. Murphy, Ph.D. received his doctorate in psychology from United States International University in 1978. He engaged in post-doctoral training at Mercy

Hospital and Medical Center in San Diego, California in 1975-1976 in the field of child psychology. Since then, his practice has gravitated to forensic matters and involves general psychological consultations. He specializes in child abuse, domestic violence, sexual deviance, and criminal behavior.

Dr. Murphy was somewhat familiar with the term "developmental disability" and he had once served as a regional center consultant early in his practice. He had not provided such services in a number of years, however, and he acknowledged that his clinical specialty does not involve assessing the developmentally disabled.

43. Alexandra was referred by Crittenden to Dr. Murphy for the purpose of a "brief developmental assessment." Dr. Murphy met with Alexandra, her social worker, and a foster parent at his offices on June 21, 2006, about four months after Dr. Zimmerman evaluated Alexandra. Dr. Murphy obtained a background and history that was essentially consistent with the background and history obtained by other examiners. He reviewed previous assessments, but he did not summarize them in his narrative report. Dr. Murphy, like Dr. Zimmerman, believed it was virtually impossible for an individual to attain a significantly higher IQ score on a properly administered, standardized assessment of intelligence than that individual's actual cognitive abilities permitted.

Initially, Alexandra did not present as a mentally retarded person. Dr. Murphy observed Alexandra's speech was very simple, yet relatively direct and well organized. She was not spontaneous, but she responded to questions and direction. Her grooming was appropriate, but Dr. Murphy learned Alexandra's foster mother participated in all aspects of her daily care. Alexandra was well oriented to person, place, and time. There was no evidence of hallucinations or delusions. Alexandra's affect was blunted.

Dr. Murphy administered the Vineland-II Adaptive Behavior Scale to assess Alexandra's basic level of functioning in various areas including communication, daily living skills, and socialization. Alexandra's scores were well below the average range in those areas tested, resulting in an overall adaptive behavior composite score of 69, which was equivalent to two standard deviations below the norm.

More specifically, Alexandra demonstrated a receptive communication score equivalent to a person of 9.6 years old, an expressive communication scores equivalent to that of a person 10.6 years old, and a written communication score of a person equivalent to 9.10 years old. In the area of daily living skills, Alexandra achieved a raw score equivalent to a person 11.6 years of age, a domestic living score equivalent to a person 10.4 years of age, and a community living score equivalent to a person 10.10 years of age. With regard to socialization, she demonstrated interpersonal relationship scores equivalent to a person 5.6 years of age, play and leisure scores equivalent to a person 12.0 years of age, and coping skills equivalent to a person 5.11 years of age.

Dr. Murphy concluded that the adaptive behavior results from the Vineland-II was "in keeping with years of evidence for both intellectual performance and adaptive behavior

performance that is very similar" and that Alexandra was "in need of continued supervision and direction for all areas of her general functioning."

Dr. Murphy administered the Kaufman Functional Academic Skills Test, which demonstrated that Alexandra had "deficits in her basic academic functioning which are significant and offer serious concerns regarding issues of rehabilitation and future education for this young woman." The Beery VMI test results were "at approximately the six- to seven-year range, further suggesting the possibility of longstanding developmental deficits."

Dr. Murphy's *DSM-IV-TR* diagnosis was:

Axis I: Deferred.

Axis II: Mild Mental Retardation.

Dr. Murphy testified that Alexandra needed to be placed in a structured situation where she would receive supervision, and that in the absence of such an environment, it was likely she would be victimized. A structured environment was indicated due to Alexandra's significant limitations in her intellectual abilities and adaptive functioning.

44. With regard to the subtest scatter that was evident in the previous cognitive testing, Dr. Murphy testified that such scatter was not unusual, that some scatter was common, and that it was not uncommon for there to be a difference between verbal and performance IQ scores. Such variations did not necessarily invalidate the testing.

When asked how Alexandra could have scored so high in Dr. Chang's testing, Dr. Murphy testified, "She could have had a really good day." He testified that while her relatively high IQ score was a valid profile for that day, the most reasonable approach to take in the investigation of Alexandra's cognitive abilities was to consider all of the testing that was administered (and which was clearly not invalid due to illness, accident or other events) and that consideration of all that data would result in a realistic view of an Alexandra's actual abilities on a day-to-day basis, as opposed to a view based upon a best-day basis.

Other Matters

45. Kristy Loufek has known Alexandra since June 2001. Loufek visits with Alexandra about once a month. She described Alexandra as very childlike, clingy, and easily upset, even though "she looks like an adult." Loufek described what she believed to be deficits in Alexandra's daily living skills including diet ("She tends to fixate one item, like cheese or cereal, and she overeats."), mobility ("She cannot use public transportation without supervision."), money-handling ("She gets her allowance and spends it all impulsively at once."), social interaction ("She hugs strangers and people she does not know."), and employment ("She was fired from the kennel"). Loufek was quite certain Alexandra could not live independently.

Alexandra's needs and services plan included an Axis II diagnosis of "borderline intellectual functioning" and it noted difficulties with such daily tasks as laundry and chores. The development of healthy communication skills in an age appropriate fashion was one of the discharge criteria mentioned in the plan, as was the development of personal safety skills and age-appropriate relationships.

Quarterly progress reports filed with the County of San Bernardino mentioned Alexandra's inappropriate boundaries, her immaturity ("Emotionally, she presents as a being 7 or 8 years old: sucking her thumb, carrying around stuffed animals and tantrumming when she does not get her way."), her constant need for attention, her struggle to complete tasks, the use of a list to help her complete tasks, the need for constant prompts and reminders, her ability to accomplish tasks when she had staff by her side, her inability to adapt to change, and her recognition that she did not function as others her same age.

Loufek testified that when placement at Rancho Damacitas proved to be too challenging for Alexandra, she was moved to a lower functioning family home environment where she was much less frustrated and was much happier. Alexandra was currently enrolled in a transitional school "and she loves it." She has a foster sister with Down Syndrome, with whom she has become quite close.

Loufek conceded she had no training in the diagnostic assessment of developmentally disabled persons.

46. Karri Crittenden is a social worker who has had contact with Alexandra on a weekly basis since January 2005, observing Alexandra in public and in several home settings. Crittenden believed Alexandra had significant limitations in communication, interpersonal skills, safety, use of community resources, health, and functional academic skills. Crittenden provided various real life examples to support her beliefs in this regard.

Crittenden conceded she had no training in the diagnostic assessment of developmentally disabled persons.

47. Sara San Juan was Alexandra's foster mother from January 2005 through September 2006. San Juan showed Alexandra how to walk to school and Alexandra was successful after five to seven trainings. However, when San Juan gave Alexandra a map to travel to a neighbor's house that was less than two blocks away, Alexandra became lost, got into a car with a stranger (even though she had been told she should not accept a ride from a stranger), and was ultimately transported home by the good Samaritan. Alexandra had no fear of strangers. Alexandra could put cereal in a bowl and add milk, but she was unable to cook eggs or toast a frozen waffle. According to San Juan, the process involved in these tasks was too complicated for Alexandra to learn. Alexandra was able to ride the bus to school, but she never woke up on time so she rarely took the bus. Alexandra immediately spent any money she had and she overdrew an ATM account without understanding why. She had essential hygiene skills, but she needed reminders to brush her teeth. Alexandra sometimes forgot her address.

48. Jackie Restivo, Alexandra's special education teacher at Orange Glen High School, testified. Her testimony is included in Factual Finding 26.

49. Alexandra testified. She appeared to be in her late teens and was somewhat overweight. She was dressed in simple, appropriate clothing and responded to questions in a simple manner. Alexandra knew the name of the family with whom she had been living for the past couple of months, but she did not know her address. Alexandra said she was enrolled in a school to help her to "become independent" and the other students were "awesome," but she could not recall how long the classes were or exactly what she was being taught. Alexandra said that she was working at two animal shelters where she cleaned and groomed animals, and that her goal was "to be calm and treat the animals right." She said she hoped to become a veterinarian or a sign language teacher. Alexandra said she had been in a special education class at Orange Glen High School. She liked the class and the other students in it. Alexandra said she "loves to clean" and attends church regularly with her foster family. She attends a youth group at church. She said she was traveling to with her foster family Arizona sometime in the future, but she was not certain when. She likes to swim, draw, learn about the Bible, and listen to all kinds of music (except rock). She buys her own CDs at the music store.

In her answers to questions and in her general fund of knowledge, Alexandra ultimately appeared to be quite slow mentally.

Arguments

50. Claimant's attorneys argued that the relatively high test results obtained by Dr. Chang's may have been the result of a "practice effect." This argument proceeded on the assumption that Alexandra might have taken a WISC-III within the month before Dr. Chang administered his test. This argument was purely speculative.

Claimant's attorneys argued that regardless of the IQ scores Dr. Chang obtained, Alexandra's eligibility should not be measured on a "best moment of her best day" approach as suggested by Dr. Zimmerman. While a "best moment of the best day" standard might disqualify an individual from receiving regional center services and supports on the basis of mental retardation, the use of a best day standard should not disqualify that individual from eligibility under the 5th Category where limited intellectual functioning not amounting to frank mental retardation was associated with significant adaptive deficits. This argument made considerable sense.

Claimant's attorneys also argued that Alexandra had received and was receiving treatment similar to that required for mentally retarded individuals, which qualified her for regional center services under the 5th Category. Although this was not a particularly detailed argument, there was evidentiary support for it.

51. The Inland Regional Center argued that the assessments over the past ten years have consistently indicated Alexandra is not mentally retarded and that she has academic skills which are inconsistent with those possessed by a mentally retarded individual or an

individual who is similar to a person with mental retardation. The Inland Regional Center observed that Dr. Chang, Dr. Krakoff, and Dr. Zimmerman, who had the most experience of any examiners in the field of diagnosing a developmental disability, believed Alexandra was functioning in the "low average to borderline" range of intelligence The Inland Regional Center's argument that Alexandra was not a mentally retarded person was far more convincing than the argument to the contrary.

The Inland Regional Center argued that the comparison of subscale scores compiled by Dr. Zimmerman disqualified Alexandra from having a condition similar to mental retardation. This argument was not as well founded and it was inconsistent with Alexandra's personal, social, and educational history.

The Inland Regional Center argued that Alexandra's low adaptive functioning was likely the result of her many mental health diagnoses over the years, the personal and social deprivations she endured, together with her lack of motivation during testing. This argument ignored the profound effect of Alexandra's borderline intellectual functioning on her ability to meet life's demands and challenges in an effective manner. In fact, Alexandra appears to have accomplished the most when she has been provided with treatment similar to that required for mentally retarded persons (e.g., placement in a special education classes with other mentally retarded persons, placement in a lower functioning foster homes, and placement in a transition program).

Finally, the Inland Regional Center argued that Alexandra's placement in program designed for mentally retarded persons was inappropriate and it "could be detrimental to her potential for growth." That argument lacked merit and was disingenuous. If it were true, then no one in the 5th Category could be safely given regional center services and supports. If it were true, then the Inland Regional Center would never be able to meet its obligation to provide each eligible consumer with an *individualized* program plan that takes into account the consumer's strengths, weaknesses, needs, and preferences.

Evaluation

52. Does Alexandra properly have a diagnosis of mental retardation?

No. Alexandra is not mentally retarded, even though she has on occasion completed assessments where her IQ scores fell into the mildly mentally retarded range. Mental retardation - as defined by the *DSM-IV-TR* - is classification that requires significantly subaverage general intellectual functioning – an IQ score of about 70 or below – obtained through a standardized, individually administered assessment, which is accompanied by significant limitations in adaptive functioning in at least two areas including communication, self-care, home living, social/interpersonal skills, work, leisure, health, and safety. The onset must occur before age 18 years.

On at least one occasion, Alexandra attained an IQ score significantly higher than 75 (the base of 70, plus a measurement error of five IQ points), a result no person with mild mental retardation could obtain. It was not established that Dr. Chang's test was improperly

administered or that there was any other reasonable explanation for the elevated IQ scores. On the basis of this reliable assessment, it is concluded as a factual matter that Alexandra is not properly diagnosed with mild mental retardation.

53. Does Alexandra possess a disabling condition closely related to mental retardation?

Yes. Even though her "best-day" IQ scores established that Alexandra is not mentally retarded, the history and pattern of her other IQ scores established that Alexandra has borderline average-day cognitive abilities, i.e., in the 70 to 80 IQ score range. Alexandra's situation has been very much like the situation of mildly mentally retarded persons described in the *DSM-IV-TR*:

> "Mild mental retardation is roughly equivalent to what used to be referred to as the educational category of 'educable.' . . . As a group, people with this level of Mental Retardation typically develop social and communication skills during the preschool years (ages 0-5 years), have minimal impairment in sensorimoter areas, and often are not distinguishable from children without Mental Retardation until a later age. By their late teens, they can acquire academic skills up to approximately the sixth-grade level. During their adult years, they usually achieve social and vocational skills adequate for minimum self-support, but may need supervision, guidance, and assistance, especially when under unusual social or economic stress. With appropriate supports, individuals with Mild Mental Retardation can usually live successfully in the community, either independently or in supervised settings."

The credible evidence established Alexandra's borderline intellectual functioning has been consistently accompanied by significant limitations in several areas identified in the *DSM-IV-TR* including safety, work, social/interpersonal skills, and self-care. Using the title 17 criteria, the evidence established Alexandra has experienced significant functional limitations in the areas of learning, self-care, self-direction, capacity for independent living, and economic self-sufficiency. Dr. Murphy documented the existence of these limitations through his recent testing.

Alexandra's significant functional limitations are directly related to her subaverage intellectual abilities; they are not solely the result of psychiatric disorders or learning disabilities, even though Alexandra has been diagnosed with these comorbid conditions. The existence of comorbid conditions in persons with conditions similar to mental retardation is predictable.

Alexandra's disabling condition is closely related to mental retardation, it originated before she was 18 years old, and it will continue indefinitely.

54. Does Alexandra require treatment similar to that required for mentally retarded individuals?

Yes. Alexandra has been treated as a mildly mentally retarded person for most of her life. She has almost always been in special education classes, usually with an eligibility diagnosis of mental retardation. Alexandra has historically not met with much success when upon her promotion to higher functioning classes, after which she was reinstated to classes and institutions designed for the mildly mentally retarded. Alexandra's teacher and school administrator, who knew her best in the education setting, believed Alexandra to be mentally retarded and they provided her with instruction consistent with that provided to a mildly mentally retarded person. Alexandra, like many mentally retarded persons, is incapable of living on her own.

The concern that Alexandra's placement in programs designed for mentally retarded persons could be detrimental to her potential for growth was not supported. To the contrary, it was disproved. The Inland Regional Center is capable of meeting its obligation to provide Alexandra with an *individualized* program plan that takes into account her strengths, weaknesses, needs, and preferences, and which maximizes her integration into the mainstream life of the community and prevents her dislocation but does not stunt her personal growth.

Alexandra's need of treatment similar to that required for mentally retarded individual is closely related to her limited intellectual abilities, it originated before she was 18 years old, and it will continue indefinitely.

LEGAL CONCLUSIONS

1. In administrative proceedings, as in ordinary civil actions, the party asserting the affirmative generally has the burden of proof, including the burden of persuasion by a preponderance of the evidence. (See e.g., *McCoy v. Board of Retirement* (1986) 183 Cal.App.3d 1044, 1051-1052.)

In this proceeding, claimant had the burden to establish that he has a "developmental disability" within the meaning of Welfare and Institutions Code section 4512, subdivision (a) by a preponderance of the evidence.

2. The legal standards required to conclude an individual has a developmental disability are set forth in Factual Findings 2-14.

3. *Mason v. Office of Admin. Hearings* (2001) 89 Cal.App.4th 1119, which is referred to in more detail in Factual Finding 13, considered the interpretation of the language referring to a "disabling condition [] found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation . . . . " The *Mason* court concluded "although section 4512(a) is somewhat unclear due to the use of imprecise words, such as 'similar' and 'closely related to,' the statute and its implementing regulations, when considered as a whole, are sufficiently clear so as to avoid a constitutional vagueness challenge." (*Id*. at 1123.)

The issue in *Mason* was whether the regional center was correct in its contention that part of the Lanterman Act should be found to be void for vagueness. That issue here is very different from that question. *Mason* does not stand for the proposition that guidelines adopted by a professional association of regional centers are entitled to special deference, nor does *Mason* compel a conclusion that once several regional center professionals have reached a determination concerning an applicant's eligibility under the 5th Category, that determination is inviolate and not subject to review.

4. It was not established that Alexandra is mentally retarded. However, claimant established by a preponderance of the evidence the presence of a developmental disability that is closely related to mental retardation and, further, she established by a preponderance of the evidence that she has a developmental disability requiring treatment similar to that required by mentally retarded individuals.

This conclusion is based on all Factual Findings and on all Legal Conclusions.

ORDER

Claimant's request for services and supports from the service agency as a developmentally disabled person under Welfare and Institutions Code section 4512, subdivision (a), on the basis of her 5th Category eligibility is granted.

NOTICE

This is the final administrative decision. Both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within ninety days.

DATED: _____

_____
JAMES AHLER
Administrative Law Judge
Office of Administrative Hearings